UNIVERSITY OF VIRGINIA HEALTH SYSTEM

0900000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

Department Of Medical Assistance Services (DMAS) - Intensive Rehabilitation

60-DAY RECERTIFICATION STATEMENT

I. Recertification Statement:

In accordance with 42 CFR 456.60, I certify that ___________________________(patient's full name) continues to be appropriate for inpatient rehabilitation services and shall meet the Medicaid intensive rehabilitation criteria for the next 60 days as set forth in 12 VAC 30-60-120. This recertification is based on my review of the individual's current medical record documentation.

II. Criteria Determination:
(In order to meet intensive rehabilitation services criteria the recipient must require all the items listed below)

The rehabilitation program cannot be safely and adequately carried out in a less intensive setting; and

The recipient is able to actively participate in the intensive rehabilitation treatment plan developed by the interdisciplinary team; and

The interdisciplinary coordinated team approach is required; and

The recipient requires rehabilitation nursing services for patient/family education in addition to skilled nursing care; and

The recipient requires at least two of the four therapies:
(Check the appropriate boxes)

☐ Physical Therapy services on a daily basis

☐ Occupational Therapy services on a daily basis

☐ Cognitive Therapy services on a daily basis

☐ Speech-Language Pathology services on a daily basis

III. Physician Signature required:

______________________________ ______________________________

Physician Signature (month/day/year)